DEPARTMENT OF THE ARMY
Madigan Army Medical Center
Tacoma, Washington 98431-1100

MAMC Regulation
Number 40-127

28 May 2002

Medical Services
PAIN MANAGEMENT

1. Purpose. This regulation outlines the Madigan Army Medical Center (MAMC) plan for pain assessment and management.

2. References. Required and related publications and prescribed and referenced forms are listed in Appendix A.

3. Responsibilities.

a. Clinic/Service Chiefs.

(1) Ensure staff education.

(2) Ensure staff compliance with this regulation.

(3) Ensure copies of the Patient Bill of Rights (MAMC HD 13) and Pain Control Pamphlet (MAMC HD 16) are available in clinic/inpatient area.

(4) Incorporate pain assessment into medical record review criteria.

b. Health Care Providers.

(1) Perform a focused assessment of patients with pain when indicated.

(2) Educate patients/family members of the importance of effective pain management.

(3) Prescribe appropriate analgesics and/or adjuvants.

(4) Educate the patient about possible side effects of analgesics/ adjuvants.

(5) Assess for adverse effects and treat appropriately.

(6) Document assessment/findings/education in the patient’s chart.

(7) Consult other services as necessary.

(8) Reassess pain during subsequent clinic visits to determine effectiveness of treatment and document findings.

c. Nursing Personnel and Clinical Pharmacists.

(1) Screen for and document the presence/absence of pain.

(2) When pain is present, complete and document a comprehensive pain assessment as warranted by the patient’s medical conditions.

(3) Administer medications as prescribed by providers in accordance with MAMC policy.

(4) Provide non-pharmacological pain relief therapies and educate patients and family members about these methods of pain relief.

(5) Educate patient and family members of the potential adverse effects of medications.

(6) Educate patient and family members of the importance of effective pain management.

(7) Notify providers when a patient’s pain is unrelieved by prescribed therapies.

(8) Reassess pain after pharmacological and non-pharmacological interventions and document findings.

(9) Assess for adverse effects, intervene appropriately, and document.

(10) During discharge planning, identify patients with potential pain control problems and collaborate with physicians, physical therapy and pharmacy to develop an appropriate plan of care.

d. Medics/Certified Nursing Assistants/Certified Medical Assistants.

(1) Perform initial screening for the presence/absence of pain and document appropriately.

(2) Provide non-pharmacological pain relief therapies (i.e., positioning, heat, cold, or distraction) as ordered by the provider.

(3) Notify nursing staff and/or providers of patient-reported pain levels.

e. Pharmacy Personnel.

(1) Provide patient education.

(2) Educate on potential drug/drug interactions, through use of the Pharmacy Data Transaction Service (PDTS), and drug/food interactions.

4. Policy and Procedures.

a. Pain Management Goal. The goal of pain management is to relieve the physical and psychosocial symptoms associated with pain while maintaining the patient's level of function to promote optimal recovery and healing.

b. Pain Assessment. The effective treatment of pain is contingent upon appropriate pain assessment. Pain is an extremely subjective experience and as such, the patient is the best judge of the severity and relief of pain. If the patient is unable to report, other methods to assess pain include family or others close to the patient reports of pain, patient behavior and physiological parameters.

c. Screening for the Presence of Pain. During the initial assessment, patients with pain will be identified. In the ambulatory care setting, patients identified with pain will be further assessed as warranted by their medical conditions. In the inpatient setting, pain will be assessed and documented per the MAMC Inpatient Pain Clinical Standard http://www.mamc.amedd.army.mil/Clinical/standards/pain_main.htm.

d. Comprehensive Pain Assessment.

(1) If pain is present, a more comprehensive assessment will be performed as warranted by the patient's medical conditions. A comprehensive pain assessment should include the following items as indicated by the condition:

(a) Quality, patterns of radiation (elicit and record the patient's own words whenever possible).

(b) Location.

(c) Pain severity.

(d) Onset, duration, variations and patterns.

(e) Alleviating and aggravating factors.

(f) Present pain management regimen and effectiveness.

(g) Pain management history (including a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response, manner of expressing pain).

(h) Effects of pain (impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration, etc.).

(i) The patient's pain goal (including pain severity and goals related to function, activities, quality of life).

(j) Physical exam/observation of the site of pain.

(2) If an initial comprehensive pain assessment has been completed during a previous visit, another comprehensive assessment will not be required if:

(a) Pain is not the chief complaint; the patient has stable, chronic pain; there is no increase in pain from baseline; and the pain does not interfere with normal function or activity.

(b) The patient is presenting for a follow-up appointment and the assessment is unchanged. In this case, the provider will document an abbreviated annotation that documents no change in the initial assessment and focuses on the response to current treatment.

(3) When a patient presents to a clinic and reports pain unrelated to the condition for which the patient is being seen, the presence of pain, and if warranted, both location and severity of pain, will be noted briefly on the top of the SF 600 (Health Record – Chronological Record of Health Care) and the patient will be referred back to the Primary Care Manager (PCM) or Urgent Care Center as appropriate.

e. Pain Severity Scales. The severity of pain is measured with a pain severity scale. Appendix B illustrates the scales currently in use at MAMC.

(1) Adults. Use the 0-10 Numeric Pain Rating Scale with adult patients. The number reported by the patient is the pain score and should be documented in the medical record (0 = no pain; 1-3 = mild pain; 4-6 = moderate pain; 7-10 = severe pain).

(2) Children. Use the adapted 0-10 Wong-Baker Faces Pain Scale for children older than three years.

f. Behaviors Potentially Indicative of Pain.

(1) Facial/audible expression of distress (e.g., grimaces, moans, crying, noisy breathing).

(2) Ambulation and posture (e.g., movement in a protected or guarded fashion; limping, frequent shifting of position; frequent stops when ambulating).

(3) Avoidance of activities (e.g., frequent lying down, avoidance of specific movements).

(4) Other behaviors believed to indicate pain, distress or suffering (e.g., wringing hands, using a cane or wearing a cervical collar).

g. Inpatient Ongoing Pain Assessment. Ongoing pain assessment will be performed on inpatient units in accordance with the MAMC Inpatient Clinical Standard.

h. Pharmacologic Management of Pain. Individualized plan of care may include opioids, acetaminophen, NSAIDS, COX-2 inhibitors, antidepressants, anticonvulsants and other adjuvant agents.

i. Professional Education. The adequate management of pain is contingent upon knowledge and attitudes of the health care providers caring for the patient in pain. Recommendations for professional education are:

(1) Medical education. Pain management education will be a component of the provider's continuing medical education program.

(2) Nursing education. Pain management education will be a component of the nursing continuing education program.

(3) Pharmacy education. Pain management education will be a component of the nursing continuing education program.

j. Patient Education.

(1) It is essential that patients have information regarding pain assessment and management in order to dispel common misconceptions related to pain, enable the patient to effectively manage their pain and side effects, and enable the patients to communicate that they have unrelieved pain. Written information regarding pain management will be made available to adult patients and to guardians of children.

(2) Pharmacy personnel will verify that any patient receiving an analgesic prescription has been given verbal and/or written information and understands these instructions.

The proponent agency of this regulation is the Quality Services Division. Users are invited to send comments and suggested improvements to Chief, Quality Services Division.

FOR THE COMMANDER:

OFFICIAL:

VAL J. MARTIN
Lieutenant Colonel, MS
Interim Chief of Staff

//s//
MICHAEL L. AMARAL
Major, MS
Deputy Chief of Staff

DISTRIBUTION:
Electronic Bulletin Board

Appendix A
References

Section I
Required Publications

MAMC Inpatient Pain Clinical Standard
http://www.mamc.amedd.army.mil/Clinical/standards/pain_main.htm

Section II
Related Publications

Publication No. 92-0032, U.S. Department of Health and Human Services, Public Health Service, Clinical Practice Guidelines, Acute Pain Management: Operative or Medical Procedures and Trauma

Publication No. 94-0592, U.S. Department of Health and Human Services, Public Health Service, Clinical Practice Guidelines No. 9, Management of Cancer Pain

Section III
Prescribed Forms

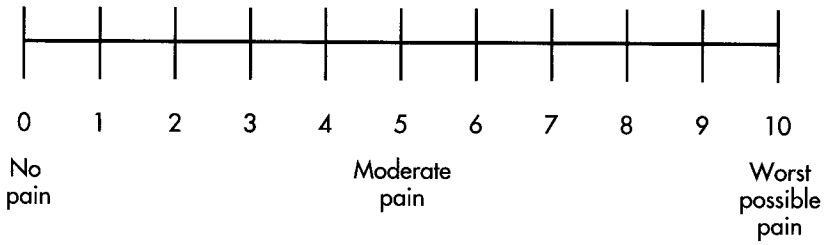
MAMC HD 16
Pain Control Pamphlet

Section IV
Referenced Forms

SF 600
Health Record – Chronological Record of Medical Care

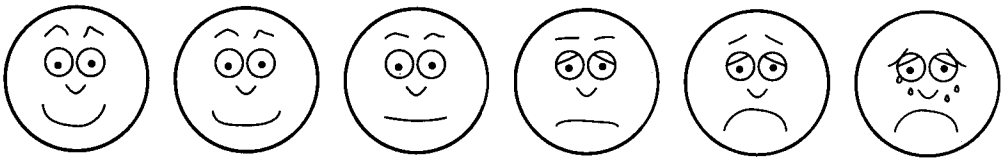
MAMC HD 13
Patient Bill of Rights

Appendix B
Pain Severity Scales



B-1. Numeric Pain Rating Scale. Ask, “If 0 is no pain and 10 is the worst possible pain, please give a number that indicates the amount of pain you are having now.”

Wong Baker Faces Pain Scale



0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

B-2. Faces Pain Scale. Explain to the person that each face is for a person who feels happy because he/she has no pain (hurt) or sad because he/she has some or a lot of pain.

Face 0 is very happy because he/she doesn’t hurt at all.
Face 2 hurts just a little bit.
Face 4 hurts a little more.
Face 6 hurts even more.
Face 8 hurts a whole lot.
Face 10 hurts as much as you can imagine, although you don’t have to be crying to feel this bad.
Ask the person to choose the face that best describes how he/she is feeling.

The Wong-Baker Faces Pain Scale is recommended for persons age three years and older.